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Intensive care survivors' experiences of ward based care: Meleis' theory of nursing transitions and role development among critical care outreach services.

Ramsay P, Huby G, Thompson A and Walsh T.

Abstract:

Aims and objectives: To explore the psychosocial needs of patients discharged from Intensive Care, the extent to which they are captured using existing theory on transitions in care and the potential role development of critical care outreach, follow-up and liaison services.

Background: Intensive Care patients are at increased risk of adverse events, deterioration or death following ward transfer. Nurse-led critical care outreach, follow-up or liaison services have been adopted internationally to prevent these potentially avoidable sequelae. The need to provide patients with psychosocial support during the transition to ward care has also been identified, but the evidence base for role development is currently limited.

Design and methods: Twenty participants were invited to discuss their experiences of ward-based care as part of a broader study on recovery following prolonged critical illness. Psychosocial distress was a prominent feature of their accounts, prompting secondary data analysis using Meleis et al's mid-range theory on experiencing transitions.

Results: Participants described a sense of disconnection in relation to profound debilitation and dependency and were often distressed by a perceived lack of understanding, indifference or insensitivity among ward staff to their basic care needs. Negotiating the transition between dependence and independence was identified as a significant source of distress following ward transfer. Participants varied in the extent to which they were able to express their needs and negotiate recovery within professionally mediated boundaries.

Conclusion: These data provide new insights into the putative origins of the psychosocial distress that patients experience following ward transfer.

Relevance to clinical practice: Meleis et al's work has resonance in terms of explicating Intensive Care patients' experiences of psychosocial distress throughout the transition to general ward-based care, such that the future role development of critical care outreach, follow-up and liaison services may be more theoretically informed.

Keywords: Intensive Care, Transitional Care, Critical Care Outreach, Qualitative Descriptive, Patient-Centred Care, Research in Practice

What does this paper contribute to the wider global clinical community?

- Meleis et al's (2000) mid-range theory on experiencing transitions has resonance in terms of explicating those aspects of patient experience which characterise, facilitate and impede a healthy response to transitions in care
- The data in this study highlight an important limitation of Meleis et al's theory; its failure to take into account the perspectives of multiple stakeholders in the transitional process or indeed the congruence between them.

INTRODUCTION

The emergence of Critical Care Outreach Services

Since the 1990's, it has been increasingly acknowledged that survivors of critical illness are at increased risk of adverse events, deterioration and death following ward transfer (Story *et al* 2006, NICE 2007). The notion of sub-optimal care; delays in diagnosis, treatment or referral, deficiencies in patient assessment and inadequate or inappropriate management

(Quirke *et al*, 2011) emerged in the late 1990's and has been implicated worldwide in these "potentially avoidable" sequelae (McQuillan *et al* 1998:1853, Wallis *et al* 1997).

Recognising that acutely unwell patients are often managed on general ward areas where staff may be ill equipped to deal with the acuity and complexity of their needs (Whittaker & Ball 2000, Cutler 2000a, 2000b, Cox *et al*, 2006), relevant policy initiatives in the United Kingdom include *Critical to Success* (Audit Commission, 1999), *Comprehensive Critical Care* (DoH, 2000), *Quality Critical Care* (Critical Care Stakeholder Forum, 2005) and more recently, *Acutely ill patients in hospital* (National Institute for Health and Clinical Excellence, 2007).

Key recommendations as part of an integrated approach to care include (i) systems for the identification and management of acutely ill patients and those at risk of deterioration i.e. early warning and track and trigger systems and (ii) the development of critical care outreach, follow-up or liaison services (hereafter termed Critical Care Outreach Services (Rowan, Adam, Ball *et al*, 2004). These initiatives have led to decreased rates of serious adverse events (Story *et al*, 2006), increased rates of survival to hospital discharge (Ball *et al* 2003, Garcea *et al* 2004) and decreased rates of readmission to ICU (Ball *et al*, 2003).

BACKGROUND

Critical Care Outreach Services (CCOS) role development

CCOS were mandated in England through government policy and funding, with three key objectives: to avert Intensive Care Unit (ICU) admissions/ensure timely admission; enable ICU discharges; and to share critical care skills with general ward staff (*Comprehensive Critical Care*, DoH 2000). It is noteworthy, however, that role development of (predominantly nurse-led) CCOS evolved in accordance with local need i.e. no explicit model was mandated in the United Kingdom and developmental and evaluative activities were somewhat limited (Department of Health NHS Modernisation Agency, 2003). Elsewhere internationally (particularly Australia), CCOS developed through professional interest (Endacott & Chaboyer, 2006) and in recognition of the psychosocial distress, transfer or relocation anxiety that patients commonly experience as part of the transition to ward-based care (Green & Edmonds 2004, Chaboyer *et al* 2005b, Kleinpell 2010).

Patients often struggle to adjust to the reduced immediacy of nursing care on the general wards (Odell 2000, McKinney & Deeny 2002, Beard, 2005), commonly reporting a sense of abandonment and vulnerability (Chaboyer *et al*, 2005a, Strahan & Brown 2005, Field *et al*, 2008), which may manifest in the anxiety, depression and emotional lability widely described among this patient group (Odell 2000, Chaboyer *et al* 2005a, Strahan & Brown 2005). The physical debilitation associated with critical illness, moreover, has been described as "inexplicable and worrying" (Jones & O'Donnell, 1994:90) and a "critical defining characteristic" of the psychosocial distress survivors experience following ward transfer (McKinney & Deeney, 2002:327).

The need to provide psychosocial support throughout the transition to ward care has been identified internationally (Green & Edmonds 2004, Chaboyer *et al* 2004, Endacott & Chaboyer, 2006). Its nature, scope and efficacy remains ill-defined, however, and existing approaches to CCOS role development remain somewhat atheoretical. This paper therefore explores patients' experiences of and responses to psychosocial distress during ward based care with explicit reference to transitional theory and for the purpose of guiding role development among CCOS.

Nursing theory on transitions in care

The earliest conceptualisations of transitions are attributed to anthropology and the work of van Gennep in the 1960's (Kralik *et al*, 2005); defined in terms of social rituals or rites of passage throughout the life course e.g. the transition to adulthood, marriage and

parenthood. Later conceptualisations, importantly, incorporate *the individual's response* to a disrupted or new social reality, a process of adaptation and mastery of a new sense of self (Kralik, Visentin & van Loon 2005). An expansive typology has subsequently been posited, wherein transitions may be developmental e.g. childhood to adolescence; situational e.g. bereavement; organisational e.g. changes in leadership or policy, or related to health and illness (Schumacher & Meleis 1994, Meleis, 2010). A widely held definition is the:

“...passage from one life phase, condition, or status to another...a multiple concept embracing the elements of process, time span, and perception. (Transition) refers to both the process and the outcome of complex person-environment interactions...and is embedded in the context and the situation.” (Chick & Meleis, 1986:239)

Transition is a central concept in nursing, given its relevance across a range of clinical and substantive issues in relation to health and illness (Schumacher & Meleis, 1994). Meleis et al's mid-range theory is arguably the most well developed among the extant literature and has been used to explicate experiences of chemotherapy (Schumacher, 1994), menopause (Im, 1997), relatives' experiences of nursing home entry (Davies, 2005) and recovery from depression (Skarsater and Willman, 2006). There has been remarkably little critique of Meleis et al's (2000) theoretical framework, however; the extant literature is concerned instead with its development as a mid-range theory. This paper therefore attempts to explore the theoretical and therapeutic implications of Meleis et al's framework as it relates to patients' transitions to ward-based care following critical illness.

METHODS

Design

The qualitative data presented here were part of a broader mixed methods study exploring recovery among survivors of prolonged critical illness at up to six months following hospital discharge (Ramsay, 2011). Twenty participants took part in individual semi-structured interviews, the content of which was iteratively developed around the critical illness “journey” (see box 1). Patient narratives were then used to explore the patient centredness of generic health related quality of life (HRQoL) questionnaires, which are increasingly utilised to characterise symptom burden and recovery following critical illness.

Box 1 here: Indicative interview guide

Participants and setting

Inclusion criteria comprised survival following ≥ 14 days' mechanical ventilation in an ICU. Exclusion criteria comprised patients with a primary neurological diagnosis, acute psychiatric disorder, the inability to communicate in English and geographical constraints. Twenty two patients (two of whom died prior to interview) were recruited. Attempts at purposive sampling according to age, gender, illness severity on ICU admission and pre-existing morbidity were compromised by the small number of eligible and accessible participants throughout the recruitment period (n=73 over 18 months). All except one were emergency admissions; a summary of their characteristics is provided below. All data are presented as medians and interquartile ranges (1st and 3rd).

Table 1 here: participant characteristics

Participants were recruited following discharge from two ICUs within university-affiliated teaching hospitals in the east of Scotland. ICU A was an 18 bed, medical-surgical combined ICU/High Dependency Unit (HDU), admitting ~1100 patients annually. ICU B was a 16 bed, medical-surgical combined ICU/HDU, admitting ~750 patients annually. Participants were discharged to single sex general ward areas comprising between 24 and 48 beds in a

combination of single and 4 bed rooms. The mean bed occupancy rate was ~85% (Information Services Division Scotland, 2012). Staff complement was approximately 1 nurse per 6-8 patients, ~65% of whom were Registered Nurses.

Ethical considerations

Ethical approval was granted by the local Research Ethics Committee. Participants were approached on the general ward and assessed for ongoing delirium (a prevalent acute confusional state) using a validated screening tool prior to requesting informed consent. In order to ascertain survival and avoid distressing the relatives of patients who had died following hospital discharge, participants' General Practitioners were contacted by telephone before arranging for interview. Due to the often highly emotive nature of enquiry, a small number were accompanied by family members. Participants were also provided with the contact details of a local ICU Clinical Nurse Specialist, should they have wished to access additional psychosocial support.

Data collection and primary analysis

The data were collected solely by the lead author as part of her Doctoral research (Ramsay, 2011). Primary analyses were concerned with (i) the effects of critical illness related morbidity upon patients' everyday lives following hospital discharge and (ii) the extent to which these were captured by the Short Form 36 (Ware & Sherbourne, 1992); the most validated and widely used generic HRQoL questionnaire among this patient population. Participants were invited to discuss their experiences of ward-based care as part of a broader semi-structured interview (see appendix 1) and were afforded significant freedom to discuss in depth those issues which were of most concern to them.

With participants' consent, the interviews were recorded using a digital voice recorder, transcribed verbatim and entered onto a data analysis software programme (NVIVO 8, QSR International, Australia). Emergent and common themes were identified through repeated reading and re-reading of the data. In order to explore whether and how the Short-Form 36 captured participants' experiences and conceptualisations of recovery, a systematic coding framework was iteratively developed with reference to its component dimensions i.e. physical and social function, role limitations due to physical or emotional problems, mental health, energy/vitality, pain and general health perception. An alternative conceptualisation and model was subsequently developed. Findings were reported at regular academic supervisory meetings and credibility was assessed through member checking (Lincoln and Guba, 1985), wherein two participants reviewed the reports and provided detailed verbal and written confirmation that they reflected their experiences.

Secondary data analysis

Psychosocial distress was a prominent feature of participants' accounts of ward care, prompting secondary analysis i.e. investigation of an emergent issue which was only partially addressed in the primary study (Heaton, 2008). The primary data had been holistically coded as "patients' experiences of ward care" in an attempt to "grasp basic themes or issues...by absorbing them as a whole rather than by analysing them line by line" (Dey 1993:104) and was explored with reference to the extant literature on transfer or relocation anxiety (Green & Edmonds 2004, Chaboyer et al 2005b, Kleinpell 2010). Transitional theory was subsequently identified as an interpretive and explanatory framework within which to re-analyse the data, among which Meleis et al's (2000) work was arguably the most well developed. A second systematic coding framework was therefore iteratively developed following repeated reading and re-reading of the data and with reference to its component dimensions.

RESULTS

The data are presented here with reference to the component dimensions of Meleis et al's (2000) model of transitions (figure 1). These include their *nature* i.e. types, patterns and

properties; *conditions* which facilitate and inhibit transitional progress and *patterns of response* i.e. process and outcome indicators.

Figure 1 here: Meleis et al's (2000) model of nursing transitions

Types and patterns of transitions

Survivors of critical illness undoubtedly experience multiple simultaneous and complex transitions upon ward transfer, which are health and illness-related, situational and organisational in origin. These include, for example, the transition from: (comparative) health to life-threatening illness (and vice versa); highly specialist, technical and individualised care versus more general care; a sense of comparative security within the now familiar ICU to one of vulnerability and unpredictability; survival to recovery and from "learned helplessness" to independence (McKinney and Deeney, 2002: 326).

Transitional properties

These are described in terms of:

- awareness: perception, knowledge and recognition of a transition experience
- engagement: the degree to which the individual demonstrates involvement in the process e.g. by actively seeking information, actively preparing and proactively modifying activities
- change and difference: the nature of change, its temporal processes, perceived importance and personal, familial and societal norms and expectations
- time span: perceived temporality
- critical points and events: turning points associated with increasing awareness or more active engagement in the transition process (Meleis *et al*, 2000)

Patients are sedated for much of their ICU stay. Amnesia, delirium (an acute confusional state) and delusional memories of a persecutory nature are extremely common in the early stages of ward based recovery. Participants were often able to provide only fragmented accounts of their admitting illness, ICU stay, ward transfer or early ward experiences, indicating a lack of awareness and/or engagement in the process. Several likened their earliest experiences of ward care, however, to an awakening from a dream-like state, a return from some ill-explained absence, or a renewed sense of situational awareness.

"...it all just suddenly clicked into place...it suddenly became a hospital. I suppose I was...getting the drugs out of my system. Certainly, those first days, I was in the twilight zone..." (James)

Inexplicably finding oneself on a hospital ward fostered, for some, a vague sense of foreboding regarding precipitating events, and engagement (as a means of making sense of one's altered circumstances) was rarely facilitated by ward staff.

"It's amazing. You know you're on a ward. You know you're there for a reason, but...I dunno if...well, maybe a part of me switched off. Maybe I didn't want to know...I asked, eventually, and all they said was, "you've been very unwell." (Andy)

Change and difference were defined by the typical early physical sequelae of critical illness, including profound weight loss, muscle wasting, generalised weakness, fatigue, and impaired mobility.

"I couldn't walk. I was very, very weak. It took me all my time to get out of bed. When I started...my legs...because I'd lost 2 and a half stone. And all my muscle was gone." (James)

Participants often described a limited appreciation of the nature and severity of their critical illness and, indeed, of their often significant functional impairment (Ramsay, 2011).

“I just didn’t have any concept of how weak my body was. It just never occurred to me that I couldn’t use my legs and things yet.” (Lynne)

Time span and critical points were thus reflected in the ostensibly “sudden” recognisance of one’s profound debilitation and functional limitations. These data posit engagement as a critical feature of the transitional process, with implications for the ways in which participants made sense of and responded to these precipitous, profoundly altered and ill-explained physical states. Meleis *et al* (2000) usefully direct attention, moreover, towards the tension between patients and clinicians in terms of their discrete transitional awareness. The following (and indeed later) data indicate limited recognisance among the latter.

“I just felt they (the nursing staff) were a bit blasé. I don’t think they realised how ill he’d been...they just sort of...saw him as he was when he came to them. It upset me sometimes....that perhaps they expected more of him than he was capable of...” (Sally, James’ wife)

Transitional conditions

These are described in terms of *factors which facilitate or inhibit healthy transitions* and include personal conditions (e.g. meaning, expectations, cultural beliefs and attitudes), community conditions (e.g. social support or access to relevant information) and societal conditions (e.g. a sense of stigmatisation or marginalisation) (Schumacher & Meleis 1994, Meleis *et al*, 2000). A key concern among participants, due to often profound debilitation, was dependence upon nursing staff for a range of previously taken-for-granted self-care activities, including using the bathroom and attending to personal hygiene. Several found this unparalleled dependence inherently demoralising.

“It’s quite upsetting for somebody...well, relatively young, still in their right mind, having to be washed, toileted and all the rest of it.” (Christine)

While participants were broadly appreciative of the care they received, given observed staffing constraints, several provided emotive accounts of a perceived indifference or insensitivity among nursing staff to their ostensibly basic care needs.

“I had to get some assistance having a seated shower. I couldn’t stand because I was so weak...and they maybe showed a bit of impatience with me there” (Dave)

The following excerpt suggests that ward staff (here, the participant’s attending Consultant) may simply dismiss patients’ concerns, perhaps perceiving debilitation to be a routine consequence of *any* severe illness or a small price to pay for survival.

“I said, “I should’ve been given exercises (in ICU).I shouldn’t be in this state!” Dr Jones said to me, “Well, that can’t be helped”” (Jane)

Participants’ concerns, in several instances, extended to the receipt of (non) specialty specific or fragmented care. One participant, transferred to a medical ward following a post-operative pneumonia described, with some consternation, the nursing staff’s apparent inability or reluctance to manage her surgical wound.

“They kept saying, “You should be in Orthopaedics. We don’t know what to do with this””. I was apologising every time I had to buzz them because my wound was bleeding...they just didn’t want the hassle.” (Alison)

Others expressed more general concerns regarding continuity of care and shortfalls in communication.

“...*even in my fuzzed head*, I was aware on a number of occasions that whoever was momentarily in charge of me had scant knowledge of who I was and how I got there.” (John, my emphasis)

These data outline a number of factors which were seen to inhibit a healthy transition, which are broadly characterised as a lack of engagement (or “understanding”) among ward-based clinicians.

Process indicators

These are described in terms of *patterns of response* which either facilitate a healthy transitional experience or expose individuals to vulnerability or risk, comprising:

- Feeling connected
- Interacting
- Location and being situated
- Developing confidence and coping

Reflecting previous research (Odell 2000, McKinney & Deeny 2002, Beard, 2005), many reported a sense of isolation and vulnerability in relation to the reduced immediacy of nursing care. Importantly, several remarked upon the dilemma inherent within sacrificing or vocalising their own needs in a clinical environment where there were others (invariably the frail elderly) “worse off”.

“They’re busy on the wards (the nurses)... they’ve got a lot of other patients...so *sometimes you had to be more vocal*” (Anne, my emphasis)

Several reported a sense of demoralisation in response to care which often failed to meet their needs. Whilst several reported “getting on with it” as best they could, one participant challenged the seemingly untenable expectations among nursing staff with regard to her continued dependence.

“One of the nurses actually got really upset and started to cry when I explained how I felt...she was really taken aback.” (Lynne) (sounds emotional)

Very few, however, voiced their concerns. Having been “stranded” in a chair in some considerable discomfort, Pat dissuaded relatives from complaining on her behalf.

“I said, “Don’t rock the boat, because I’m still here”. You know, you are actually scared to complain because the power is with them (the nurses). I think that happens a lot in hospitals.” (Pat)

Others, intriguingly, appeared not to perceive ongoing debilitation as deserving of acute hospital resource. One participant, for example, concealed her ongoing impairment from her attending physician; a strategy which inadvertently delayed referral for formal rehabilitation. She later alluded to “nagging” in order to expedite one.

“The Consultant would come round and I’d say, “I’m fine”. And I mean, I was *bed bound* half the time! Well, I used to say it myself, “I’m just taking up a bed here.”” (Christine, her emphasis)

These data describe broad patterns of interaction which varied in the extent to which they affected more responsive care. The variability between successive clinicians, in terms of

their perceived compassion, also mediated these strategies and evoked considerable uncertainty among participants.

Outcome indicators

Identified indicators comprise the *mastery of new skills* and *the development of a fluid yet integrative identity*. In the later stages of ward-based recovery, the former was encapsulated by “getting on with it” i.e. negotiating independence in the face of radically altered bodily states, unprecedented dependence and limited supportive resource. Participants varied, as the previous data demonstrates, in the extent to which they were able to do so. Each reported, nonetheless, upon the importance of “determination”, including its perceived centrality to recovery following discharge home.

“I was *determined* I was gonna get mobile as quick as possible. I’ve got that determination. I’ve had it all my life.” (James, his emphasis)

Also important in the mastery of new skills was the receipt of pertinent information. Appraised several months post-discharge of the likelihood of ICU-acquired weakness (during a follow up appointment with an ICU Clinical Nurse Specialist), one participant expressed significant frustration regarding her protracted recovery.

“I don’t know if it’s something that happens...maybe varying degrees, but your body feeds off your muscles (in ICU). I just thought, “I’m not trying hard enough”. Had I have had this knowledge, it would’ve been...easier for me to accept.” (Jane)

The development of fluid integrative identities relates to “identity reformulation”, wherein patient perspectives become “bicultural” rather than “monocultural”. Several participants reported “putting on a brave face”, actively demonstrating increasing independence in order to garner additional support.

“If they (the nurses) see you’re making an effort, that you’re trying to help yourself, they have more time for you.” (Andy)

Participants also identified and negotiated professionally mediated criteria of recovery in order to effect a widely expressed desperation for hospital discharge.

“I remember the day I got up the stairs. I headed up in front of the physiotherapist, so that he didn’t see my face...because it took every ounce of strength I had to get up there.” (John)

Among one of the few participants to receive a weekend pass (the purpose of which, generally speaking, is to inform both clinicians and patients of readiness for hospital discharge), Elizabeth concealed ongoing impairment from her attending clinicians.

“...when I got home, I really struggled. I’m not saying any more actually, because they might not have let me home if they’d known how much I struggled.” (Elizabeth)

Meleis et al (2000) note a degree of overlap between process and outcome indicators, suggesting that the determination of when a transition is complete must be flexible and variable, dependent upon the nature, type and pattern of transition. Professionally mediated criteria of recovery (or readiness for hospital discharge) represent one such example, wherein their accomplishment rarely prepared participants for life at home.

“When I got home, I got the shock of my life. But I said,” “Well, you said you could do it.”” (Bill)

These data, in summary, help provide a broader understanding of the nature of the transitional process, the conditions which inhibit healthy transition and likely patterns of patients' response; the purpose of which is to elicit nursing therapeutics which are congruent with the individual's experience (Meleis et al, 2000).

Nursing therapeutics

The central premise of nursing therapeutics is to assist clinicians to facilitate healthy transitional responses among patient groups. These data, however, suggest a limited awareness among ward-based clinicians with regard to both the psychosocial distress patients often experience in relation to the transition to ward care and the typical early physical and psychosocial sequelae of critical illness. Increasing understanding of these sequelae, their common manifestations and patterns of response may have widespread preventive and/or therapeutic implications. CCOS staff, the vast majority of whom are experienced critical care nurses, are ideally placed to engage with and educate both patients and clinicians to urge, as Carr (2002) suggests, patience and forbearance as they struggle to recover.

"They (clinicians) may come to realise that their (patients') dependence is not all psychological, but has its roots in true physical weakness." (Carr 2002: 73)

Importantly, participants also identified the mobilisation of inner resources (notably "determination") as facilitating healthy transitions. In many cases, however, inner resources were mobilised in response to sub optimal care, an expressed "desperation" for hospital discharge or as a means of garnering support or prestige among nursing staff.

"I was on a ward with three of them...one of the guys just wouldn't help himself at all. One of the nurses said to me "I wish I could get this lot to motivate themselves like you have!"(James)

Among the few to be transferred for formal rehabilitation, one participant attributed her accelerated progress to a more relaxed clinical environment, increased rehabilitative resource, a shared ethos among clinicians and a sense of community amongst her fellow patients. Importantly, she also described the ways in which staff actively harnessed her own inherent determination.

"It was a like a different world, really. They had time to speak to you. It was...*very much up to you to get yourself better, but they provided the back up*. They were so encouraging... they really made you feel like you could do it." (Christine, my emphasis)

These data in particular direct attention to cultural or organisational aspects of recovery which may be out with acute hospital based clinicians' sphere of influence. Supporting and expediting the mobilisation of individuals' inner resources has the potential to become a critical feature of contemporary transitional practice and research in relation to nursing therapeutics, however, given global pressure to shorten acute hospital lengths of stay and promote continued recovery in community settings.

DISCUSSION

The putative origins of participants' psychosocial distress are encapsulated well within Chick and Meleis' (1986) earlier notion of *disconnectedness* as the most pervasive characteristic of the transitional process i.e.

“a disruption of the linkages on which the person’s feelings of security depend...occasioned by a loss of familiar reference points, incongruity between expectations and experiences, and a discrepancy between perceived needs and the availability of, as well as access to, means for their satisfaction” (Chick & Meleis 1986: 240).

Disconnectedness was evidenced by participants’ often emotive accounts of a precipitous awakening to or incremental realisation of radically altered bodily states, which were manifestly ill-explained. An unprecedented dependence upon others for a range of previously taken-for-granted activities was associated with a sense of isolation and despondence, mediated largely by the perceived insensitivity with which their needs were often addressed. Despite a wealth of somewhat dated literature on the psychosocial distress ICU patients experience following ward transfer, this paper is the first to actively incorporate Meleis *et al*’s (2000) theory into an analysis of patients’ accounts and to explicate the transition between dependence and independence as a critical defining feature.

Previous authors have suggested that Meleis *et al*’s (2000) model has the tendency to view individuals as passive recipients of nursing intervention (Davies, 2005). Participants in this study, however, were seen to *actively* negotiate the transition between dependence and independence in terms of the ways in which they interpreted and responded to radically altered bodily states, perceived shortfalls in the delivery of care and professionally mediated criteria of recovery. This process of engagement and indeed the mobilisation of inner resources is nonetheless contingent upon on the involvement of multiple stakeholders in the transitional process: critical care and CCOS clinicians, ward staff (including rehabilitative clinicians), health services managers and indeed community-based clinicians. Critical features of future CCOS role development therefore include (i) the provision of informational and psychosocial support whereby patients’ inner resources might be optimised and (ii) knowledgeable and sensitive mediation between these multiple stakeholders.

CONCLUSION

Transitional theory requires empirical testing in a diverse range of healthcare settings if it is to guide nursing practice (Meleis *et al* 2000, Davies 2005). There is a danger nonetheless, that explanation may be imposed rather than allowing understanding to emerge from those experiencing transitions of care (Chick & Meleis, 1986) and a more pragmatic, experiential focus has been advocated (Field *et al*, 2008, McKinney & Deeny 2002). The data in this study demonstrate that Meleis *et al*’s (2000) framework has resonance in terms of explicating those aspects of experience which characterise, facilitate and impede patients’ transition to ward care. An important limitation, nonetheless, is its failure to acknowledge the perspectives or complex inter-relationships between the multiple stakeholders previously described; future transitional research must therefore consider the dynamic and reciprocal nature of the relationships between patients and clinicians (Davies & Nolan 2003, Davies 2005).

Future transitional research must also reflect the challenges of contemporary clinical practice e.g. increased acuity and complexity of the patient population, workforce and organisational constraints and the extent to which these impinge upon clinicians’ ability to facilitate healthy transitions. The data in this study suggests, furthermore, that the congruence (or otherwise) between staff and patient process or outcome indicators (i.e. healthy patterns of response, the mastery of new skills and the development of fluid and integrative identities) requires sensitive exploration, given their development here in response to perceived shortfalls in care and, importantly, their likely impact upon longer-term outcomes.

RELEVANCE TO CLINICAL PRACTICE

Nursing staff, by virtue of their “thereness” (Chick & Meleis 1986:247) and continuity are ideally situated to facilitate the patient’s transition to ward care and recovery. Participants in

this study, however, reported a lack of understanding and a perceived indifference or insensitivity to their care needs as detrimental to the transitional process. Reflecting, to a large extent, the imperatives of *Comprehensive Critical Care* (DoH 2000), both CCOS role development and educational provision among ward staff reveals an explicit focus upon the assessment and management of patients at risk of deterioration. The nature and scope of providing psychosocial support to patients, a key role of CCOS has not been well articulated in the literature. These data represent a patient-focused and theoretically explicit endeavour to address this gap in provision suggesting that CCOS role development, in addition, should take into account the perspectives of and between multiple stakeholders in the transitional process.

LIMITATIONS

This study has a number of limitations. Whilst participants were afforded significant freedom to discuss aspects of experience which were of most concern to them, the primary study incorporated a broader focus of enquiry which may have failed to capture participants' perspectives on ward care in sufficient detail. These data also relate to participants with a prolonged critical illness and therefore the severest forms of critical illness-related morbidity; caution is therefore urged in their interpretation. Furthermore, the data were collected at up to six months following hospital discharge and may be prone to recall bias.

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Author Contributions

The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org/ethical_1author.html), as follows:

- 1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data,
- 2) drafting the article or revising it critically for important intellectual content, and
- 3) final approval of the version to be published.

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Appendix 1: Indicative interview topic guide

General questions	“Prompts & Probes”
How did you feel about being transferred to the ward?	You may not remember very much about that time... some people don't Some people see going to the ward as a positive step, while others might be apprehensive... How well prepared did you feel?
How were you physically, when you were transferred to the ward?	Many people describe feeling very tired... some have problems with weight loss, weakness or mobility What kind of issues, if any, did you have? What was the main issue? In what way(s) did that affect you?
How were you psychologically?	Some people “come to” on the wards What was your understanding, at that time, of how you ended up in Intensive Care? What were you able to piece together, from what other people (e.g. family and friends) told you? What were your feelings, at that time, about what had happened to you?
What were your general impressions of the care you received on the ward?	The Intensive Care Unit and the wards can be very different in lots of ways... What were the main differences for you? How would you describe your time on the ward? Can you think of something which was typical of good care? And “not so good” care? Perhaps something you experienced yourself... or you saw happen with other patients
In terms of helping you getting you back to normal, what kind of help did you get on the ward?	How much help did you need with everyday things like washing and going to the bathroom, for example? Did you feel that you received as much help as you needed? Did you feel able to ask for help? If not, why not?

Table 1: participant characteristics

Participant characteristics (n=20)	
Age (years)	61(49,71)
Male gender (%)	57
APACHE score* (illness severity)	24(21,29)
Length of ventilation (days)	28(20,40)
ICU length of stay (days)	35(24,47)
Ward length of stay (days)	24(15,52)

Data presented as medians and interquartile ranges (1st and 3rd)

*APACHE is an illness severity scoring system based upon

Figure 1: Meleis et al's (2000) model of nursing transitions